**Dr. Ben Ramos, DC, MS, CSCS**
11588 Sorrento Valley Road, Suite #22
San Diego, CA 92121

FLOWFORCE REHAB

## GENERAL INFORMATION (PLEASE PRINT CLEARLY)

Name:

Dob:

Sex: ☐ Male ☐ Female

Height:

Weight:

Phone - Cell:

Home:

Address:

City:

State:

Zip:

Email:

Referred by:

*(Your email will NOT be shared with any 3rd parties and is only used for general office communication)*

Emergency Contact:

Phone#:

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ DP

Drivers Lic #

SSN:

Name of Spouse/Parent:

Spouse/Parent Contact#

Chief Complaint(s):

## CURRENT COMPLAINTS

Chief complaint(s):

Date of Injury:

Date Symptoms Began:

How did your pain begin?
☐ Immediately after a specific event ☐ After multiple events ☐ Gradually developed ☐ No apparent reason

Are your pain or symptoms:
☐ Improving ☐ Worsening ☐ Not changing

Are your pain or symptoms:
☐ Constant (75-100% of time) ☐ Frequent (51-75%) ☐ Occasional (25-50%) ☐ Intermittent (25% or less)

Have you ever had a similar problem before? ☐ Yes ☐ No If so, When:

Does anything decrease your pain or symptoms?

What makes your pain worse?

Is this interfering with your
☐ Work ☐ Sleep ☐ Daily Routine ☐ Sports ☐ Recreation ☐ Other? If so, please explain:

What is the functional goal you would like to achieve? *(i.e. return to sport/recreation, regain personal independence, become stronger, play with kids again etc.)*

FLOWFORCE REHAB

## CURRENT COMPLAINTS *Continue....*

Have you been treated for any of these conditions in the past year? ☐ Yes ☐ No If YES, please check:

☐ Surgery ☐ Injections ☐ Physical Therapy ☐ Supportive devices

☐ Medications _____ ☐ Other _____

Did they help? ☐ Yes ☐ No

Prior tests, results and dates: (X-ray, MRI, CT, ultrasound, lab, other):

Have you ever been treated by a chiropractor before: ☐ Yes ☐ No If yes, please provide:

Date of last visit: Name of previous chiropractor:

How would you rate your general stress levels?

☐ None ☐ Minimal ☐ Moderate ☐ Great

Are your complaints affecting your ability to work or otherwise be active?

☐ Some restrictions (able to perform light duty work & household tasks) ☐ No effect

☐ Need limited assistance with common everyday tasks ☐ Need assistance often

☐ Significant inability to function without assistance ☐ I am totally disabled (impaired and cannot care for self)

How much time do you spend? (please check)

| | | | | |
|---|---|---|---|---|
| Sitting | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day | ☐ None |
| Standing | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day | ☐ None |
| Computer work | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day | ☐ None |
| Strenuous manual labor | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day | ☐ None |
| Moderate manual labor | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day | ☐ None |
| On the Phone | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day | ☐ None |
| Driving | ☐ Most of the day | ☐ Half of the day | ☐ A little of the day | ☐ None |

Please List each area of your symptoms in order of severity. Then at the scale below, mark (X) at a point along the that demonstrates the level of severity.

| **Areas of Symptom** | No Pain or Symptoms | | | | **Severity** | | | | | | Worst Pain Imaginable |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

In the area to the right please indicate where you are experiencing pain or symptoms by drawing in the letter abbreviations on the diagrams

**Sharp Pain = P**

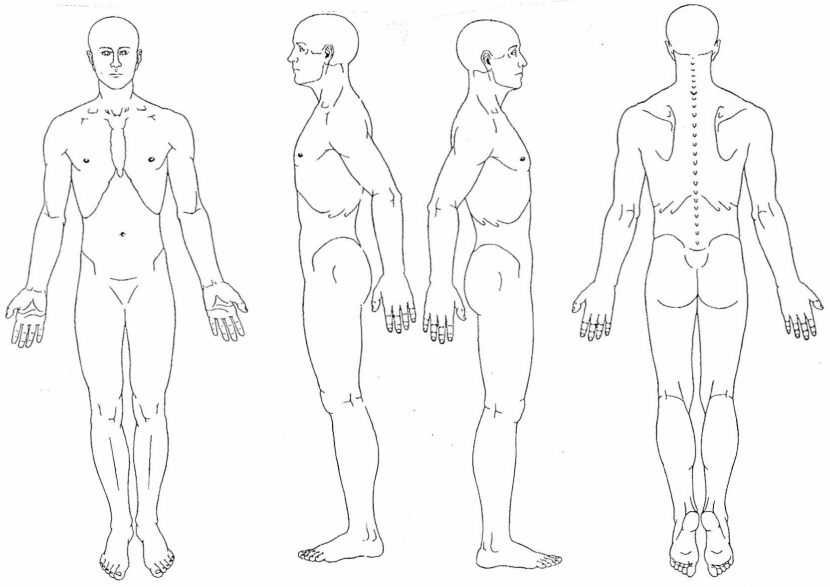
**Stiffness = S**

**Tingling = T**

**Dull Pain = D**

**Numbness = N**

**Burning = B**



FLOWFORCE REHAB

## MEDICAL HISTORY

Have you been treated for any other conditions in the last year? ☐ Yes ☐ No If yes, please describe :

Date of Last physical exam: Findings?

| | |
|---|---|
| Have you had any dental care or minor surgery in the last 4 weeks? | ☐ Yes ☐ No |
| Are you, or do you think that you may be pregnant? | ☐ Yes ☐ No If yes, # of weeks: |
| Do you ever experience night sweats? | ☐ Yes ☐ No |
| Do you experience night pain that keeps you from sleeping? | ☐ Yes ☐ No |
| Have you had any unexpected weight loss? | ☐ Yes ☐ No |
| Do you experience any numbness? | ☐ Yes ☐ No |
| Do you experience any tingling? | ☐ Yes ☐ No |
| Do you experience any muscle weakness? | ☐ Yes ☐ No |

| Please List Any: | Date: | Please Describe: |
|---|---|---|
| Motor Vehicle Accident | | |
| Recent Work Injury | | |
| Sports/Recreational Injury | | |
| Falls or Other Traumas | | |
| Surgeries | | |
| Hospitalizations | | |
| Other Medical Conditions | | |

| Medication/Supplement | Dosage | Reason for taking | Takin since (date) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## FAMILY HEATH HISTORY

| Family Members | Medical Conditions: Past and Present (IE: Heart Disease, Cancer, Diabetes, Thyroid Problems, Mental Health Disorders, Genetic Disorders ect.) |
|---|---|
| Mother | |
| Father | |
| Sister | |
| Brother | |

FLOWFORCE REHAB

## GENERAL INFORMATION

| General Habits | None | Light | Moderate | Heavy |
|---|---|---|---|---|
| Coffee/Tea | ☐ | ☐ | ☐ | ☐ |
| Tobacco | ☐ | ☐ | ☐ | ☐ |
| Recreational Drugs | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ |
| Appetite | ☐ | ☐ | ☐ | ☐ |
| Soft Drinks | ☐ | ☐ | ☐ | ☐ |
| Water | ☐ | ☐ | ☐ | ☐ |
| Salty Foods | ☐ | ☐ | ☐ | ☐ |
| Sugary Foods | ☐ | ☐ | ☐ | ☐ |
| Artificial Sweeteners | ☐ | ☐ | ☐ | ☐ |
| Alcohol | ☐ | ☐ | ☐ | ☐ |

Do you have any difficulty with the following?

- Please place "**N**" in the space if the condition is Now
- Please place "**P**" if the condition was in the Past

| | | | | | |
|---|---|---|---|---|---|
| | Abdominal Pain | | Gout | | Nervousness |
| | Alcoholism | | Gynecological Problems | | Pneumonia |
| | Allergy | | Hardening of Arteries | | Poor Appetite |
| | Anemia | | Hearing Problems | | Prostate Problems |
| | Arthritis | | Heart Disease | | Sciatica |
| | Asthma | | Headaches | | Short of Breath |
| | Cancer | | Hemorrhoids | | Sinus Trouble |
| | Chest Pain | | Hepatitis | | Sleeplessness |
| | Colds/Infections | | High Blood Pressure | | Stress |
| | Colon Trouble | | HIV / AIDS | | Stroke |
| | Constipation | | Indigestion | | Thyroid Trouble |
| | Depression | | Kidney Trouble | | Ulcers |
| | Diabetes | | Knocked Unconscious | | Varicose Veins |
| | Dizziness | | Liver Trouble | | Vision Problems |
| | Epilepsy | | Lung Problems | | Weight Gain |
| | Fatigue | | Mental Disorders | | |
| | Gall Bladder | | Nausea | | |

## SIGNATURE

| Patient's Signature | Guardian's Signature |
|---|---|
| | |
| Date | Date |
| | |

# Ramos Chiropractic & FlowForce Rehab Inc.
# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

**Ramos Chiropractic & FlowForce Rehab Inc. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.**

**DISCLOSURE OF YOUR HEALTH CARE INFORMATION**

**Treatment**

**We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.**

**Payment**

**If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. Your file, containing protected health care information, may be reviewed by the designated collection agency or authority.**

**Workers' Compensation**

**If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.**

**Emergencies**

**We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.**

**Public Health**

**As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.**

**Judicial and Administrative Proceedings**

**We may disclose your health information in the course of any administrative or judicial proceeding.**

**Law Enforcement**

**We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.**

**Deceased Persons**

**We may disclose your health information to coroners or medical examiners.**

**Public Safety**

**It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.**

**Specialized Government Agencies**

**We may disclose your health information for military, national security, prisoner and government benefits purposes.**

**Marketing and Other Communications**

**We may contact you for marketing purposes, as described below: (example)**

**"As a courtesy to our patients, it is our policy to call your home on the evening prior to your appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on you answering machine or with the**

**person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment.**

**Change of Ownership**

**In the event that Ramos Chiropractic & FlowForce Rehab Inc. practice is sold or merged with another organization, your health information/record will become the property of the new owner.**

**Your Health Information Rights**

**You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Ramos Chiropractic & FlowForce Rehab Inc. is not required to agree to the restriction that you requested.**

**You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.**

**You have the right to inspect and copy your health information.**

**You have a right to request that Ramos Chiropractic & FlowForce Rehab Inc. amend your protected health information. Please be advised, however, that Ramos Chiropractic & FlowForce Rehab Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason (s) and information about how you can disagree with the denial.**

**You have a right to receive an accounting of disclosures of your protected health information made by Ramos Chiropractic & FlowForce Rehab Inc.**

**You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.**

**Changes to this Notice of Privacy Practices**

**Ramos Chiropractic & FlowForce Rehab Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Ramos Chiropractic & FlowForce Rehab Inc. is required by law to comply with this Notice.**

**Ramos Chiropractic & FlowForce Rehab Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Ramos Chiropractic & FlowForce Rehab Inc. by calling this office at (619) 734-9794. If Ramos Chiropractic & FlowForce Rehab Inc. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.**

**Complaints**

**Complaints about your privacy rights, or how Ramos Chiropractic & FlowForce Rehab Inc. has handled your health information should be directed to DRamos Chiropractic & FlowForce Rehab Inc. by calling this office at (619) 734-9794. If Ramos Chiropractic & FlowForce Rehab Inc. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.**

**If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to**

**DHHS, Office of Civil Rights**
**200 Independence Avenue, S.W.**
**Room 509F HHH Building**
**Washington, DC 20201**

**This notice is effective as of _____/_____/_____**

**I have read the Privacy Notice and understand my right contained in the notice.**

**By way of my signature, I provide Ramos Chiropractic & FlowForce Rehab Inc. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.**

**Patient's name (print)**

**Patient or Legal Guardian Signature** **date**

# Informed Consent for
# Chiropractic Treatment and Care

I hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy (or on the patient named below, for whom I am legally responsible for) by the doctor or intern, affiliated with Ramos Chiropractic & FlowForce Rehab Inc.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise proper judgment during the course of the procedure(s) by which the doctor feels at that time, based on the facts then known, are in my best interest.

I have read, or have had this read to me, the above consent. By signing below, I agree to the above and allow the doctor or intern, affiliated with Ramos Chiropractic & FlowForce Rehab Inc. to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition and for any future condition(s) for which I seek treatment.

_____ _____

**Patient's Name (PRINTED)** **Date**

_____ _____

**Patient's Signature** **Guardian's Signature**

# Financial Policy

| Initial Exam Options | Follow Up Options |
|---|---|
| 90 Min - $250 | 60 Min - $185 |
| 60 Min - $195 | 30 Min - $110 |
| 30 Min - $120 | 15 Min - $55 |

**Payment for treatment:**
You agree to pay by cash, check, or credit card on the day that treatment is rendered. Unless we approve other arrangements in writing, the balance on your account is due and payable when the services are rendered and is past due if not paid by this time. _____ (***Initial***)

**Insurance:**
You understand that Ramos Chiropractic & FlowForce Rehab, Inc. is an *Out of Network* provider and will not be billing your insurance. You understand that upon request you will be provided with a superbill that you can submit to your insurance provider for reimbursement of any out of network benefits.
_____ ***(Initial)***

**Missed Appointment Fees:**
Patients who do not show up for an appointment or cancel with less than 24 hours' notice will be charged **the total cost of the visit unless otherwise stated by the provider**. This fee must be paid before a new appointment is scheduled and will be charged to the patient's payment account on file. Providing updates to all contact information are the sole responsibility of the patient. _____(***Initial***)

**Returned Checks:** There is a fee (currently $40) for any checks returned by the bank. _____ ***(Initial)***

**Transferring of Records:**
You understand that you will need to request in writing and pay a reasonable fee (currently $40) if you want to have a printed copy of your patient health record. You also understand that at the providers discretion, you may have access to your patient records via the providers secure electronic health record system free of charge.
_____(***Initial***)

**Effective Date:**
Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

**Patient Name (Print): _____ Date: _____**

**Patient/Guardian (Sign): _____**